SECTION 3
INJECTION (PHARMACY) CLAIM
FILING INSTRUCTIONS

Effective July 1, 2005, all pharmacy claims, except for adjustments, must be submitted electronically either through a clearinghouse, billing agent or the Medicaid website at www.emomed.com for billing and to maintain the business relationship with the Division of Medical Services. Additional information regarding pharmacy claims was published in a Medicaid Pharmacy Bulletin dated July 29, 2005.

MEDICATION BILLING
The quantity to be billed for injectable medications dispensed to Missouri Medicaid recipients must be calculated as follows:

- Containers of medication in solution (for example, ampules, bags, bottles, vials, syringes) must be billed by the exact cubic centimeters or milliliters (cc or ml), even if the quantity includes a decimal (i.e., if three (3) 0.5 ml vials are dispensed, the correct quantity to bill would be 1.5 mls).
- Single dose syringes and single dose vials must be billed per cubic centimeters or milliliters (cc or ml), rather than per syringe or per vial.
- Powder filled vials and syringes that require reconstitution must be billed by the number of vials.
- The product Herceptin, by Genentech, must be billed by milligram (mg) rather than by vial.
- Immunizations and vaccines must be billed by the cubic centimeters or milliliters (cc or ml) dispensed, rather than per dose.

Claims billed incorrectly are identified through a dispute resolution process. When these claims are identified, providers are notified and required to file adjustments to accurately reflect the quantity dispensed.

For specific questions concerning injectable medication billing, contact the Pharmacy Administration Unit at (573) 751-6963.

State of Missouri Medicaid

Hipaa Pharmacy Claim

If you are not _____, please logout   [Logout]

User: _____   Provider: [_____ ▼]

Patient Name
(Last Name, First Name) *
[_____] [_____]

Patient's ID *
[_____]

Patient Location
[0=Not specified ▼]

Prior Authorization Type Code
[0=Not specified ▼]

Other Coverage Code
[0=Not Specified ▼]

Prescription Number *
[_____]

Prescribing Physician Medicaid Number *
[_____]

Date Dispensed (mm/dd/yy) *
[___] / [___] / [___]

National Drug Code *
[___] [___] [___]

Fill Number *
[___]

Compound Indicator
[_____ ▼]

Metric Quantity (9999999.999) *
[_____]

Days Supply *
[___]

Unit Dose Indicator
[0=Not Specified ▼]

Total Charge *
$ [_____]

Other Coverage Amount
$ [_____]

Prior Authorization Number
[_____]

[Submit]   [Reset]

[Home]   [Help]

Electronic Pharmacy Claim Form Filing Instructions

NOTE: * These fields are required on all Pharmacy claim submissions.
          ** These fields are required only in specific situations, as described below.

FIELD   **DESCRIPTION**

*Patient's Last Name   Enter the patient's full last name as shown on Medicaid ID
                                   card.

*First Name   Enter the first letter of the patient's first name as shown
                                   on the Medicaid ID card.

*Patient's ID   Enter the patient's eight digit Medicaid or MC +
                                   identification number (DCN) as shown on the patient's ID
                                   card.

**Patient Location   Code identifying the location of the patient when
  (NOTE: For pharmacy   receiving pharmacy services. The valid values are:
  providers **only**.)

                                   0   Not Specified
                                   1   Home
                                   2   Inter-Care
                                   3   Nursing Home
                                   4   Long Term/Extended Care
                                   5   Rest Home
                                   6   Boarding Home
                                   7   Skilled Nursing Facility
                                   8   Sub Acute Care Facility
                                   9   Acute Care Facility
                                   10 Outpatient
                                   11 Hospice

**Prior Authorization Type   The valid values are:
  Code.

                                   0   Not Specified
                                   1   Prior Authorization
                                   2   Medical Certification
                                   3   EPSDT
                                   4   Exemption from Copay
                                   5   Exemption from Prescription
                                   6   Family Plan
                                   7   AFDC
                                   8   Payer Defined Exemption

3.3

**Other Coverage Code   Indicate whether the patient has a secondary health insurance plan. If so, choose the appropriate value. The valid values are:

0   Not Specified
1   No Other Coverage identified
2   Other Coverage Exists – Payment Collected
3   Other Coverage Exists – This Claim Not Covered
4   Other Coverage Exists – Payment Not Collected
5   Managed Care Plan Denial
6   Other Coverage Denied – Not a Participating Provider
7   Other Coverage Exists – Not in Effect at Time of Service
8   Claim is a billing for a copay

*Prescription Number   Enter the number assigned by the pharmacy or the physician's office. Enter a sequential identification number in this field. If the billing provider chooses to use a patient account number, an additional unique identifying character must be added to identify different injections administered on the same date of service. (NOTE: This number is used to sort claims submitted electronically on the remittance advice.)

**Prescribing Physician's   Enter the prescribing provider's Medicaid number or DEA
  Medicaid Number   number. If the prescribing provider is not a Missouri Medicaid provider, enter the prescribing provider's DEA number.

*Date Dispensed   Enter the date the drug was dispensed or administered in MM/DD/YY numeric format.

*National Drug Code   Enter the precise National Drug Code (NDC) assigned to the product dispensed or administered as it appears on the package. Always enter the entire number, separated, using the dotted lines to indicate where the hyphens appear, using the 5-4-2 format. If the drug code on the package is not in 5-4-2 format, enter zeroes in front of the numbers listed for each field. For example: NDC 45-143-20 is listed as 00045-0143-20.

*Fill Number   The code indicating whether the prescription is an

	original or a refill. Enter a two-digit value. 00 = Original dispensing, 01-99 = Refill number
**Compound Indicator	If billing for a compound drug, the first ingredient of a compound must be billed with a compound indicator of "0". All other ingredients must be billed with a compound indicator of "2". Otherwise, leave blank.
*Metric Quantity	Enter the metric quantity dispensed or used in administration, as follows:

Number of tablets dispensed.
Number of grams for ointments or powders.
Number of cc's (ml's) administered for products in
   solution (ampule, I.V. bag, bottle, syringe, vial).
Number of vials used containing powder for
   reconstitution.
Immunizations and vaccines must be billed by the cubic
   centimeters or milliliters (cc or ml) dispensed.
Implant (1 kit = 1 unit).

*Days supply	Enter the estimated duration of the prescription supply in days. If it is a PRN medication, use 77. **If billing for administration at a physician's office, the value should always equal 1.**
Unit Dose Indicator	Indicate the type of unit dose dispensing. The valid values are:

0 Not Specified
1 Not Unit Dose
2 Manufacturer Unit Dose
3 Pharmacy Unit Dose

*Total Charge	Enter the provider's usual and customary charge for this service.
**Other Coverage Amount	Enter the total amount received by all other insurance resources. Previous Medicaid payments, Medicare payments, cost sharing and copay amounts are **not** to be entered in this field. This field is required if the Other Coverage Code field has a value.
**Prior Authorization Number	Enter the Prior Authorization number, if applicable. Otherwise, leave blank.